ALLIANCE *for* CONNECTED CARE

June 16, 2025

Stephanie Carlton
Deputy Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

Thomas Keane, MD, MBA
Assistant Secretary for Technology Policy
National Coordinator for Health IT
U.S. Department of Health and Human Services

RE: Response to the Health Technology Ecosystem Request for Information

Dear Ms. Carlton and Dr. Keane,

The Alliance for Connected Care (the "Alliance") appreciates the opportunity to provide comments on the Department of Health and Human Services (HHS) important work to improve the health technology ecosystem. **The Alliance believes that the delivery of health care should be seamless across modalities.** We call on CMS to leverage this Health Technology Ecosystem effort to -

✓ *Ensure that patients and providers do not have to think about practice or payment barriers when considering the right modality for medical treatment.*

✓ *Modernize practice and payment requirements to unlock full potential of digital health – beyond what is possible with in-person care.*

We recognize these are ambitious goals, that challenge statutory restrictions and many years of precedent – but the represent the North Star we should all be striving for. This health technology ecosystem transformation is an opportunity to take the innovations we have seen in virtual care and fully unleash them – leveraging greater flexibility in care, seamless data flow across patients, practitioners, and settings, and optimizing the remote workforce to meet America's health needs.

Broadly, the Alliance is dedicated to improving access to care through the reduction of policy, legal, and regulatory barriers to the adoption of telemedicine and remote patient monitoring. We thank you for this opportunity to advance that agenda. Our members are leading health care and technology organizations from across the spectrum, representing health systems, health payers, technology innovators, and patient and provider groups, including many types of clinician specialty and patient advocacy groups who wish to better utilize opportunities enabled by virtual care.

Below, we offer specific areas where HHS can improve its digital capabilities to unleash virtual connected care. These recommendations build on broader infrastructure efforts for greater data sharing across systems, effective interoperability policies, and better patient access to their own care data.

Modernize practice and payment requirements to unlock full potential of digital health – beyond what is possible with in-person care.

As the Medicare population continues to age, and clinician shortages worsen, the use of technology to manage patients with multiple chronic conditions or in high-risk post-acute circumstances are not just an imperative, they a necessity. As outlined in the Alliance's comments on specific steps to lessen regulatory burdens, we believe that one key to scaling these services will be moving beyond time-based services when technology can extend the capabilities of the clinician. The Trump Administration has laid out a bold vision for the use of artificial intelligence – coding based on the time a clinician spends rather than

the outcome they achieve stands in the way of that revolution. Similarly, time-based coding limits the ability for cost-saving care-management services like remote patient monitoring to scale technological capabilities as rapidly as our aging population needs.

Another key barrier to unlocking the full potential of tech-enabled care is the removal of barriers to the provision of necessary technology to patients. Medicare should modernize safe harbor provisions to make clear that healthcare providers can supply patients with internet access and smart devices—such as smartphones, tablets, and computers—without fear of inducement penalties. In doing so, providers should not be required to implement complex technical fixes that restrict devices solely to healthcare-related use, as such restrictions diminish the utility of the device for patients while placing an ongoing maintenance burden on health systems. By enabling healthcare systems to support patients in owning versatile devices that allow them to stay engaged with their healthcare team while also benefiting their daily lives, CMS can enhance digital access and empower patients to manage their care more effectively. Simplifying inducement rules would align federal policy with contemporary healthcare needs. Notably, we believe these inducement threats have significantly diminished. As technology continues to become more ubiquitous, waivers of cost sharing are less likely to create a beneficiary inducement issue. For example – the relatively influence a subsidized tablet or monitoring device on beneficiary behavior diminishes as these items become cheaper and more widespread.

Finally, as a national payer, the Medicare program should take a leading role in ensuring seamless nationwide access to care across state lines. Our current system of state-by-state licenses stifles the ability of providers to consult with and treat Americans wherever they may be, exacerbating our workforce maldistribution issues and forcing Americans to drive to appointments that could be done virtually. To fully unleash technology-enabled care, such as telehealth, seamless data exchange must be able to flow across the health care ecosystem. The ability to practice across state lines is crucial for the delivery of care in both remote rural areas and those with practitioner shortages. This access is also needed for decentralized clinical trials, rare diseases, college students or others who travel, and many other specific use cases. According to an Alliance survey, 84% of health care practitioners and over 8 in 10 telehealth patients support the option to receive telehealth services from health care practitioners across state lines, suggesting that those who have received care via telehealth in the past view their experiences favorably. President Trump led on efforts to reform occupational licensure during his first term and that continued leadership is needed to advance efforts that will make health care more efficient and competitive. We call on the Trump Administration to exert national leadership in reforming outdated licensure restrictions that reduce competition and access in health care.

Ensure that patients and providers do not have to think about practice or payment barriers when considering the right modality for medical treatment.

As telehealth becomes fully integrated into everyday care, CMS needs to update its payment processes and requirements to reflect the real-world application of telehealth – realizing that it is often fully interchangeable with in-person care. The choice between in-person and telehealth care is a core capability of a modern, patient-centered health care system – allowing flexibility to meet the needs of the moment. For most providers, the logistical processes related to offering and supporting telehealth services are generally the same as in-person services. The majority of telehealth services are scheduled, managed, and supported by the same support staff working in the facility or medical practice.

This includes allowing the billing of services from remote locations such as the home without additional, burdensome enrollment and billing documentation requirements. CMS requirements undermine the delivery of telehealth services to Medicare beneficiaries, by requiring providers to report their home

address if the provider renders telehealth services from their homes. In an informal survey of Alliance members, the impact of this policy ending would be profound. Differentiating and reporting home addresses on billing and enrollment forms would result in a 40-times increase in the number of billing addresses tracked and reported to CMS by a health system. Multiple health systems estimated the resulting operational costs of this change at approximately $1 million in labor.[1] CMS now has a chance to leverage its active reform of the Provider Enrollment, Chain and Ownership System (PECOS) to make system-wide changes that facilitate a modernized system that reflects the real-world usage of telehealth services and decreases burdensome paperwork for providers.

Similarly, CMS should modernize interprofessional consultations to reflect the increasingly efficient modalities through which clinicians engage with each other. This means removing time constraints and removing patient consent requirements for these simple consultations. The average time used for e-Consults is low, reimbursement is low, and time and consent tracking simply create extra burden to document. We should want to encourage more clinician cooperation in the delivery of care, particularly as newer and asynchronous forms of communication allow it to improve.

CMS should encourage health plans to cover telehealth and in-person care more equally by replacing federal time and distance standards for measuring network adequacy with more qualitative standards that more accurately reflect access and utility. CMS previously noted that "a state that has a heavy reliance on telehealth in certain areas of the state may find that a provider to enrollee ratio is more useful than meaningful access, as the enrollee could be well beyond a normal time and distance standard but can still easily access many different providers on a virtual basis." Now that telehealth is widespread and proven, it is time to move to outcome focused measures – such as patient reported outcome measures that measure how well beneficiaries are served by a plan network. While broad reform is needed, we acknowledge that not all services are appropriate for telehealth and that CMS will need to ensure patients continue to have local access to care – particularly in rural areas where supply may already be limited.

CMS should act to streamline supervision requirements, allowing innovative new models of care leveraging virtual supervision that stretch the workforce while maintaining high-quality care. CMS has permanently allowed virtual direct supervision for lower acuity health care services provided incident to a physician, but has not yet acted to fully enable the ability of virtual supervision to increase efficiency and access in Medicare. In 2025, CMS adopted a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), but only for the following subset of incident-to services described under § 410.26 and for incident-to services. As described for broader telehealth services – the modality of the supervision is not the key area for CMS regulation. CMS should remain modality agnostic on how supervision is offered, provided it meets clinical needs for safety and quality.

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As you know, telehealth and remote patient monitoring can empower patients to make better decisions for their health and well-being. We look forward to working with HHS to modernize health care policies

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[1] *A system reported that it would take their operations staff around 6 hours of work per provider, per year, to add and maintain an average of three billing addresses per telehealth provider. For a health system with more than 3,300 telehealth clinicians, that results in more than 20,000 hours of additional staff work per year. Another system found similar estimates, with more than 4,500 telehealth clinicians resulting in approximately 27,000 staff hours of additional staff work per year.*

in ways that treat this virtual care more equally, and unlock its additional capabilities. If you have any questions or would like to hear from Alliance member experts on these topics in more detail, please do not hesitate to contact Rikki Cheung at rikki.cheung@connectwithcare.org.

Sincerely,

Chris Adamec
Executive Director
Alliance for Connected Care